STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155325	A. BUILDING _____ B. WING _____	R-C 04/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW VIEW HEALTH AND REHABILITATION CENTE	900 ANSON ST SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 02/16/12. This visit included the Post Survey Revisit to Complaint IN00103521 completed on 02/16/12. Complaint IN00103521 - Corrected. Survey date: April 9, 2012 Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800 Survey Team: Avona Connell, RN TC Donna Groan, RN Census Bed Type: SNF: 01 SNF/NF: 94 Total: 95 Census Payor Type: Medicare: 10 Medicaid: 79 Other: 06 Total: 95 Sample: 11 Meadow View Health and Rehabilitation Center was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to Complaint IN00103521.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Quality review 4/10/12 by Suzanne Williams, RN	{F 000}		